TAX CREDIT / RHS
ANNUAL QUESTIONAIRE FOR RECERTIFICATION
OF
FAMILY INCOME AND COMPOSITION

PROPERTY NAME
Date Received: _____

Head of Household _____
Last MI First
Co-Head/Spouse _____
Last MI First
Current Address _____

City _____ State _____ Zip Code _____ Tel # _____

Household Composition

Complete, in your own handwriting. List the Head of Household (applicant) and all other persons who will be living in your unit. Give the relationship of each family member to the head.

Member Full Name	Relationship	Date of Birth	Age	Sex	Student Y or N	Social Security #
	HEAD					

All family members 18 or over listed as Full Time Students provide the following information:

School Name & Address: _____

School Name & Address: _____

HOUSEHOLD INCOME INFORMATION
All information will be verified by a third party

For each household member age 18 or older, list current and anticipated income for the 12-month period commencing or anticipated from the date of occupancy. Include all full time, part time or seasonal employment. If a household member has more than one source of income, use a separate line for each source.

	DO YOU RECEIVE OR EXPECT TO RECEIVE	YES	NO	MONTHLY AMOUNT
1	Wages, salaries (includes overtime, tips, bonuses, commissions, self-Employment)?			$
2	Does any member work for someone who pays him/her cash?			$
3	Regular pay for a member of the armed forces?			$
4	Welfare of disability benefits (AFDC, SS GA)?			$
5	Worker's Compensation?			$
6	Unemployment benefits or Severance pay?			$
7	Child Support?			$
8	Alimony?			$
9	Education grants, scholarships or VA student benefits?			$
10	Social Security Payments?			$
11	Pensions (PERA, railroad, etc.)?			$
12	Death Benefits?			$
13	Retirements Benefits?			$
14	Annuities or life insurance dividends?			$
15	Lump sum payments (include inheritance, insurance settlements, lottery winnings, etc)			$
16	Net income from rental property?			$
17	Regular cash contributions or gifts from individuals not living in the unit?			$
18	Other, (list)?			$

Question #	Family Member	SOURCE(S) OF INCOME NAMES AND ADDRESSES (i.e. employers, public assistance office, social security, pension fund, etc.)

HOUSEHOLD ASSETS
All information will be verified by a third party

	DO YOU HAVE MONEY HELD IN	YES	NO	AMOUNT
1	Checking Accounts			$
2	Savings Accounts			$
3	Stocks			$
4	Capital Investments			$
5	Bonds			$
6	Trusts			$
7	Securities			$
8	IRA/KEOGH Accounts			$
9	Certificates of Deposit			$
10	Pension/Retirement Funds			$
11	Mutual Funds			$
12	Treasury Bills			$
13	Safety Deposit Box			$
14	Insurance Settlement			$
15	Other (list)			$
				$
16	Do you currently hold a contract for deed			$
17	Do you currently own real estate			$
	If yes, please list the location(s), number of acres owned, any expenses (i.e. taxes, insurance, etc.) and any income received:			
18	Do you have any coin collections, antique cars, gems/jewelry, stamps or any other items held for investment purposes?			$
19	Are any assets held jointly with another person?			
	If yes, list person's name and the asset(s) held jointly:			

Question #	Family Member	List Name AND Address of Bank or Institution where funds are kept. Provide copy of entire property tax statement for any real estate owned

I/we certify that I/we have _____ have not _____ sold or disposed of any asset for less than Fair Market Value during the two year (24 month) period preceding the date of this application. Any assets sold or disposed of for less than Fair Market Value are identified below.

Relationship to Head of Household	Assets Estimated Value	Date Sold / Disposed of	Amount Received

HOUSEHOLD ALLOWANCE INFORMATION
All information will be verified by a third party

All or part of your household's expenses may be allowable as a deduction from your annual income. Eligible expenses include childcare costs, payments on outstanding medical bills, medical insurance premiums, cost of assistive devices, cost of attendant care and any other medical and dental costs NOT covered by an outside source; e.g. insurance, Medicare, state agency or charitable organization.

	Do you expect to incur any of the following expenses:	Yes	No	Monthly Amount
1	Childcare which enables you or another household member to work, go to school or to seek employment			
2	Attendant care for a handicapped or disabled household member?			
3	Medicare premiums?			
4	Other medical insurance premiums?			
5	Outstanding medical bills on which you are currently paying?			
6	Cost of assistive devices for handicapped or disabled household member?			
7	Drug cost not covered by insurance?			
8	Do you receive medical assistance through the Public Assistance Program?			
9	Do you expect to have any additional medical expenses during the next twelve (12) months, i.e. glasses, dental, hearing aid batteries? If Yes, explain: _____ _____			

Question #	Family Member	List Name AND Address of Service Provider, Day Care Center, Insurance Company, Doctor, etc. (Use back of page for extra space)

PLEASE REVIEW THIS FORM CAREFULLY. IF THERE IS INFORMATION MISSING, IT WILL BE RETURNED TO YOU WHICH WILL DELAY THE RECERTIFICATION PROCESS.

I/WE CERTIFY THAT ALL INFORMATION GIVEN IN THIS QUESTIONAIRE IS TRUE, COMPLETE AND ACCURATE. I/WE UNDERSTAND THAT IF ANY INFORMATION IS FALSE, MISLEADING OR INCOMPLETE, MANAGEMENT MAY TERMINATE OUR LEASE AGREEMENT.

ALL HOUSEHOLD MEMBERS AGE 18 OR OLDER MUST SIGN BELOW

Tenant Signature _____ Date _____

Tenant Signature _____ Date _____

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December 6, 2000